DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/13/10.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445270	A. BUILDING _____ B. WING _____	09/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENNESSEE VETERANS HOME	PO BOX 10299 MURFREESBORO, TN 37129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review, and interview, the facility failed to provide assistance to prevent a fall for one (#10) of twenty-four resident records reviewed. The findings included: Resident #10 was admitted to the facility on May 6, 2008 with diagnoses including Chronic Airway Obstruction, Congestive Heart Failure, Late Effect Cerebrovascular Disease, Aortic Valve Disorder, Muscle Weakness, Alzheimer's Disease, Depressive Disorder, Psychosis, and Senile Dementia with Delusion. Medical record review of the Minimum Data Set dated April 26, 2010 revealed resident #10 had short and long term memory impairment, moderately impaired decision making skills, required extensive assistance with two plus person physical assistance for transfers, and extensive assistance with one person physical assistance for ambulation. Medical record review of the Fall Risk Assessment dated April 20, 2010 and July 13,	F 323	F323 Free of Accident Hazard/Supervision/Devices 1. Corrective action(s) will be accomplished for those residents found to have been affected. The Director of Nursing/designee will ensure that staff members providing care for Resident #10 were/will be immediately inserviced regarding his care and transfer needs to ensure immediate safety. The inservices started immediately and will be completed by October 15th. 2. The facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be take. The Director of Nurses/Designees will review and update necessary all Residents Minimum data Sets and fall risk assessments, and necessary data on all facility residents with the potential to be affected. All residents identified to be at risk will be assessed for the presence of appropriate interventions on their Resident Care Plans necessary to ensure their safety and prevent accidents. 3. Measures will be put into place and systematic changes will be made to ensure the deficient practice will not recur. The Director of Nursing /Assistant Director of Nursing/Staff development Coordinator/designee will ensure that all appropriate facility personnel have been inserviced regarding the guidelines for maintaining safe environments for the resident population and for provision of appropriate supervision ad assistance to prevent accidents by October 15th 2010.	10/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bridgette Hornbeck	Administrator	10/8/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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TENNESSEE VETERANS HOME	PO BOX 10289 MURFREESBORO, TN 37129

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F 323	Continued From page 1 2010 revealed the resident was at high risk for falls. Medical record review of the care plan dated April 28, 2010 revealed a problem addressing the risk for falls with the intervention of "...4/20/10...Have walker with in easy reach for transfers and ambulation. Requires extensive assist x 2 (by two) with ambulation and transfers..." Review of the facility document, Nurse Aide Information Sheet, updated April 20, 2010 revealed the resident required "...transfer: gait belt...2 assist...stands with extensive assist..." Further review revealed "...ambulation: 2 assist...gait belt...RW (rolling walker)..." Medical record review, of the Post Fall Nursing Assessment/Progress Note dated July 13, 2010 at 7:30 a.m., revealed the "...Resident was being transferred from bed to chair, buckled (resident) knees then had to be lowered to floor by staff..." Further review revealed the Certified Nurse Assistant (CNA) #1 and #2 were present during the event. Interview, with CNA #1 at the east nursing station on September 29, 2010 at 7:50 a.m., revealed CNA #1 was the only staff member assisting the resident during the transfer from the bed when the resident's knees gave out and was lowered to the mat. Further interview revealed CNA #1 called for assistance and CNA #2 entered the room to assist followed later by Licensed Practical Nurse (LPN) #1. Further interview confirmed the resident required extensive assistance with two plus person assistance for transfers. Interview, with CNA #2 at the east nursing station	F 323	4. Corrective actions will be monitored to ensure the deficient practice will not recur. The Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Unit managers, and Designees will review and update as necessary the resident care cards on a weekly, and as necessary basis to ensure the care cards are consistent with care provider orders and resident care needs and preferences. A sample ten percent of the in house resident census will be audited on a weekly basis to ensure accuracy of the care cards and that the assigned nursing staff members are knowledgeable of the residents care card contents, needs, desires, and preferences. These audits will commence on October 15th and will continue to be completed every week for 4 consecutive weeks, then monthly for 3 months, and reported to the Quality Assurance. Action will be taken for any areas of noncompliance.	

OCT 18 2010

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F 323	Continued From page 2 on September 29, 2010 at 7:50 a.m., confirmed CNA #2 was not present during the event. Further interview confirmed CNA #2 entered the room and saw the resident with their knees on the mat. Interview, on September 29, 2010 at 8:20 a.m. in the Board Room, with the Regional Compliance Nurse confirmed the resident required extensive assistance with two person physical assistance with transfers and ambulation after reviewing the care plan and the Nurse Aide Information Sheet.	F 323		

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